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Original Research

Vulnerable migrants' access to healthcare in the early stages of the COVID-19 pandemic in the UK

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ABSTRACT

Objectives: To understand the living conditions, changes in the service user profile, and needs of vulnerable migrants trying to access healthcare in the early stages of the COVID-19 pandemic.
Study design: Mixed methods study; using quantitative questionnaire data collected from migrant service users of Doctors of the World UK (DOTW UK) with qualitative data from free-text notes.
Methods: DOTW UK provides drop-in clinics to vulnerable migrants. Consultations switched to remote during the UK's first lockdown. We compared patient profile, well-being, healthcare access and reason for consultations of individuals attending the virtual clinic between March and September 2020 to those of the prepandemic periods between 2011 and 2018.
Results: During the pandemic, consultations dropped to under half of the prepandemic numbers, with the shift to remote consultations attracting more users outside of London. DOTW UK's user base changed to include a greater proportion of asylum seekers, younger adults (18–34) and individuals reporting good health. Socio-economic conditions and housing stability deteriorated for the majority of users. Those in the greatest need of healthcare appeared to be less able to access remote services. General practitioner (GP) registration remained the most common reason for contacting the virtual clinic with a lack of knowledge of the healthcare system being the main barrier to access.
Conclusion: The shift to virtual consultations may have exacerbated existing inequalities in healthcare access for vulnerable migrants. Given that many clinical services continue to operate remotely, it is important to consider the impact such actions have on vulnerable migrants and find ways to support access.

Introduction

The advent of the coronavirus (COVID-19) global pandemic has had a wide impact on populations across the world but with marked disparities in infection and survival rates. Early in the pandemic, it was evident that social and economic inequalities shaped people's vulnerability to the disease.[1] In the United Kingdom (UK) and United States (US), Black, Asian and minority ethnic (BAME) groups including migrants were found to experience higher infection rates.[2] The pandemic generated economic and social conditions with potential for a deleterious effect on migrant health. Findings from the UK Household Longitudinal Survey showed that migrant men experienced worse economic impacts and mental health than those born in the UK. During the UK's first lockdown, they were more likely to experience job loss, financial hardship and a reduction in working hours,[3] and BAME migrants received a lower level of financial protection.[3,4] Migrant women faced more barriers to access healthcare services during the pandemic.[5] Filipino migrants were more likely to be working in front-line positions, which increased their risk of exposure to the disease;[6] those without documents were particularly vulnerable: working and living in crowded and unsafe conditions with few social distancing or hygiene measures and fearful of accessing healthcare services.[6] Research looking at forced migrant survivors of sexual and gender-based violence found that they lived on very low incomes and had to choose between purchasing food, hygiene products and mobile phone data.[7,8] Research with healthcare providers, asylum seekers and refugees identified the digitisation of primary care and the severing of connections to support networks

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as a barrier to healthcare access.[9] Undocumented migrants' struggles to register with a general practitioner (GP) also presented an obstacle to vaccination.[10]

Clearly, the pandemic and associated measures are experienced differently according to socio-economic and migration status. However, there is a gap in knowledge about the impact of the pandemic on the most vulnerable migrants, namely rejected asylum seekers and undocumented migrants known to struggle with healthcare access prepandemic.[11] Such migrants are unidentifiable in routine or specialised surveys. This article brings new knowledge of the needs of vulnerable migrants trying to access healthcare in the early stages of the COVID-19 pandemic. Using a unique dataset from vulnerable migrant service users assembled by DOTW UK via cross-referenced social and medical questionnaires and free-text notes, we compare the health concerns and well-being status of individuals attending the clinic during and before the pandemic. We explore patterns of change in DOTW UK's service user base and the pandemic's impact on migrant groups known to struggle to access healthcare.

Methods

The data collected by DOTW UK represent a cohort of service users at risk of vulnerability. As a non-governmental organisation, DOTW UK uses consultations with volunteer doctors and nurses to support excluded people to access healthcare. From 2011 until the pandemic, most consultations were provided in a face-to-face format by clinics based in London and Brighton (now defunct). All consultations switched to a telephone service on 17th March 2020 in the UK's first lockdown. Data were collected during a phone conversation with a volunteer caseworker concerning service users' demographic profile, well-being, healthcare access and the reason for making contact (service user information form and social form) and during the consultation with a volunteer GP where this was necessary (medical form); all forms included space for free-text notes. Detailed information on the process of data collection is published elsewhere.[12]

We focus on DOTW UK's migrant service users, which include undocumented migrants, asylum seekers, refugees, European Union (EU) citizens, non-EU citizens with valid visas and refused asylum seekers. We exclude British citizens because they form a small minority of DOTW UK's service users (0.3%). With appropriate anonymisation, quantitative data were extracted from the service user information form and matched to the social and medical forms.[c] We focus on what we term the 'pandemic' period, from the DOTW UK move to remote consultations in March 2020, until the end of September 2020, and the comparative 'prepandemic' periods of the same months in 2011–2018, to explore the differences in trends between these two periods. We analyse a sample of free-text notes (those collected in April and July 2020) which we term qualitative data.

Quantitative analysis

Based on the matched results from service user and social forms, we compare 6268 unique service user consultations across the two periods (5947 before and 321 during the pandemic). Incomplete/erroneous data were corrected following discussions with DOTW UK: service users with missing information were removed from datasets and misspellings were manually corrected. The data contain missing information for some variables, which we excluded from the calculations. The effective sample sizes used in our analyses and missing data are included in the figures.

Questions asked are mainly consistent between the two periods. The sociodemographic indicators included sex, age, economic situation, immigration status and housing situation. Geographic location refers to consultations in London vs other locations. Well-being status is defined as self-reported general and psychological health. Questions about psychological health differed during pandemic/prepandemic periods. In 2011–2018, service users were asked 'how is your psychological health?' From 2020, DOTW UK used the Patient Health Questionnaire-2 (PHQ-2) question 'Over the last 2 weeks, how often have you been bothered by feeling down/depressed/hopeless?'

We use descriptive statistics, usually percentage distributions given the nature of the variables, to compare prepandemic and during-pandemic data. For each percentage, we compute 95% confidence intervals to assess differences across answer categories. We use a chi-squared test (significant at 0.05 unless specified) to assess the differences in answer distributions. When appropriate, we compare results across immigration statuses, using confidence intervals and chi-squared tests. Throughout, we use a minimum cell count of five observations.

Qualitative analysis

We use free-text notes to enable us to make sense of patterns observed in the quantitative analysis. We extract all available free-text notes for migrant service users for April and June 2020. From a total of 107, we exclude 12 as they were UK nationals or contained no data. The remaining 96 sets of notes range from a few lines to several pages and outline details of health concerns and life situations, providing an account of engagement until the problem was resolved or the contact was lost. A content analysis consists of two stages: first, we summarise characteristics of the individual case focusing on 1) service users' current health status, 2) the health services required, 3) their life situation, 4) any barriers and facilitators to accessing health services and 5) how their health concerns were resolved (or not). Then, we compare across cases to understand the range of concerns faced by service users.

The Ethical Review Committee of the University of Birmingham granted full ethical approval. All data were anonymised by DOTW UK before they were securely shared with the authors. DOTW UK's service users gave consent for data sharing when data were collected. Data were stored on encrypted devices.

Results

Number of consultations

The number of consultations from March to September in 2011–2018 was 5947, and it was 321 in 2020. Fig. 1 shows that the monthly trend of pandemic consultations is similar to the prepandemic period but dropped to under half that of the prepandemic period.

Sociodemographic characteristics

Table 1 shows that sex was equally distributed throughout the periods with females accounting for approximately 49% (2982/6024) of consultations. Service users were younger during the pandemic with a significant increase in the proportion of 18–34-year-olds from 42.7% (2476/5793) in the prepandemic period to 50.8% (163/321), and the 35–59 age group decreased from 49.6%

[c] The match was performed using unique consultation identifiers – note that any repeat consultations with the same service user are also excluded so that we only have unique service users in the data.

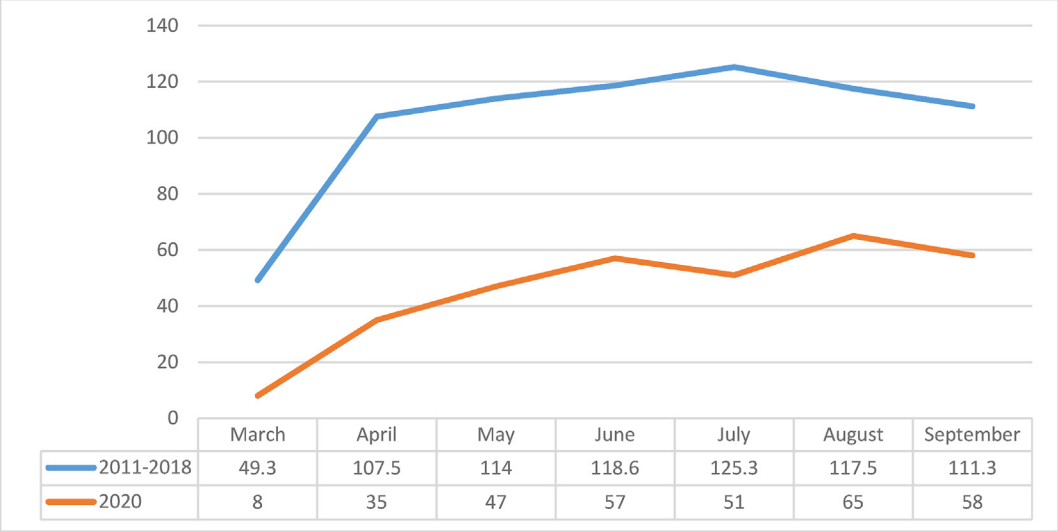

Fig. 1. Yearly averaged number of consultations during the prepandemic and pandemic periods ($N = 6268$). Values before the pandemic are averaged.

Table 1
Variable descriptions and descriptive statistics for service users prepandemic and during pandemic periods.

Variables	Prepandemic (%)	Prepandemic (*N*)	Pandemic (%)	Pandemic (*N*)	Chi- squared value	*P*-values
Sex (*N* = 6024)						
Female	49.6	2845	48.2	137	0.190	0.663
Male	50.4	2895	51.8	147		
Age group (*N* = 6114)						
0–17	2.8	164	3.1	10	8.815	0.032
18–34	42.7	2476	50.8	163		
35–59	49.6	2876	41.4	133		
60+	4.8	277	4.7	15		
Location of residence (*N* = 6100)						
London	89.8	5191	82.3	261	17.468	0.000
Outside of London	10.2	592	17.7	56		
What have you been helped with today? (*N* = 6026)						
GP registration	84.9	4843	76.6	246	15.771	0.000
NHS cost	53.2	3035	22.1	71	117.539	0.000
Antenatal care	3.3	189	8.7	28	25.621	0.000
Immigration (2013–2018, $N = 4627$)	15.4	661	6.5	21	18.444	0.000
A&E/walk in	5.2	294	4.7	15	0.144	0.704
Second care charging	2.8	160	3.1	10	0.107	0.744
Dentist	5.5	314	2.8	9	4.368	0.037
Termination of pregnancy	0.7	40	2.5	8	12.337	0.000
Foodbank	1.9	109	1.6	5	0.204	0.652
The proportions of GP registration by immigration status						
Undocumented ($N = 3621$)	87.3	3006	77.3	136	14.542	0.000
Asylum ($N = 797$)	81.8	576	86	80	0.997	0.318
Others ($N = 1158$)	85.9	959	63.4	26	15.672	0.000
In the last 3 months approximately how much money per month did you have to live on? (2013–2018, *N* = 4032)						
Above poverty threshold	17.7	664	9	25	13.976	0.000
Below poverty threshold	82.3	3089	91	254		
Housing situation of service users (*N* = 5992)						
Roofless/houseless	3.2	182	5.8	18	2246.552	0.000
Insecure/inadequate house	2.4	137	63	196		
Secure tenancy	91.6	5203	17.4	54		
Others	2.8	159	13.8	43		
Have you experienced any obstacles/barriers when accessing healthcare? (*N* = 5863)						
Lack of knowledge	25.4	1410	23.4	75	0.693	0.405
Admin barrier	25.1	1390	11.8	38	28.884	0.000
Fear of arrest	10.4	579	6.9	22	4.260	0.039
Language barrier	12.9	714	5.6	18	14.701	0.000
Financial barrier	3.7	206	4.7	15	0.764	0.382
Denied health coverage	8.1	450	4.4	14	5.881	0.015
Other barrier	2	109	2.2	7	0.072	0.789
Denied by healthcare provider ($N = 5598$)	15.3	808	1.9	6	44.002	0.000

Note: Percentages may not add up to 100% due to rounding. The prepandemic period represents March to September in 2011–2018 unless specified. The pandemic period represents March to September in 2020. The observation numbers ('*N*'s) are presented for each variable unless specified. EU citizens and non-EU citizens with valid visas make up the 'others' immigration status.'

(2876/5793) to 41.4% (133/321). The share of those over 59 or under 18 years remained similar.

During the pandemic, more service users (91%, 254/279) reported their monthly income as below the poverty line (£836 per month), a significant increase from prepandemic (82.3%, 3089/3753). Free-text notes indicated that most had no employment during the pandemic and relied on support from family and friends.

About 91% (5681/6268) of service users reported an immigration status, which we categorised as follows:

- Undocumented/no legal status: e.g. those who refused asylums, visa-overstayers
- Asylum seekers and refugees: ongoing asylum claims; granted refugee status
- Others: e.g. EU citizens; non-EU with a valid visa

Fig. 2 shows the proportion of asylum seekers which increased from 13.6% (732/5371) to 30% (93/310) during the pandemic. The share of undocumented migrants and others dropped from 65.1% (3498/5371) to 56.8% (176/310), and from 21.2% (1141/5371) to 13.2% (41/310), respectively. Analysis of free-text notes indicates that a number of service users had sought help while living in hotel accommodation; two of whom were concerned about the impact of poor quality hotel food on their health. The notes identified a few instances of "other" service users seeking advice having been trapped in the UK after travel plans were disrupted by the pandemic.

Housing

DOTW UK's location is in London. The shift to remote interactions saw the share of service users residing outside of London increase significantly, from 10.2% (592/5783) in the prepandemic period to 17.7% (56/317). During the pandemic, the proportion of service users living in secure tenancies reduced by 74.2% to only 17.4% (54/311) (Table 1). Undocumented migrants in particular reported a decline in housing stability from 92.7% (3196/3447) in secure housing to 18.5% (32/173). Analysis of notes showed that most now lived in shared rented accommodation with friends or family, often with the rent paid for by family members. The notes indicate that most felt safe for now, however, a small number reported living in exploitative circumstances or being concerned about housing stability. Some 46% (40/87) of asylum seeker service users were in 'other' types of housing during the pandemic, most likely hotels.

Health

We look at the health status through measures of general and psychological health (Fig. 3). The proportion of service users with good general health during the pandemic increased (from 38.7%, 2171/5603 to 47.4%, 144/304). Likewise, the share of service users with good psychological health increased significantly, while those with fair or bad psychological health status decreased significantly. Analysis of notes indicated that users with no or minor current health problems tended to contact DOTW UK to help them to register with a GP (possibly in case they got infected with COVID-19) while pregnant women who contacted DOTW UK for help with access to antenatal care were also in good health.

Breaking general health status down by the immigration status (Fig. 4), some variation was observed during the pandemic (significant at 0.10 level) but the general health of undocumented and other service users showed little difference. The health profile of service users within the asylum seeker/refugee category was more skewed toward poorer outcomes. Asylum seekers also showed significantly poorer psychological health than undocumented and "others" during the pandemic.

Reasons for consultation

Of 5705 service users, 59.8% before the pandemic and 38% of 321 service users during the pandemic gave two or more reasons for engaging with DOTW UK. GP registration was the main reason for consultations (84.9% before, 4843/5705 and 76.6% during, 246/321, respectively) although for undocumented migrants and "others" the proportion consulting for GP registration was reduced (see Table 1). Our analysis of notes indicates a range of reasons for needing GP registration, from seeking registration in case a health problem should arise (sometimes following a prior refusal) or to access medication, to more complex situations, including multiple acute health problems and/or the need to be classified as extremely vulnerable to receive help during the pandemic. Help with National Health Service (NHS) costs was a highly ranked reason in both

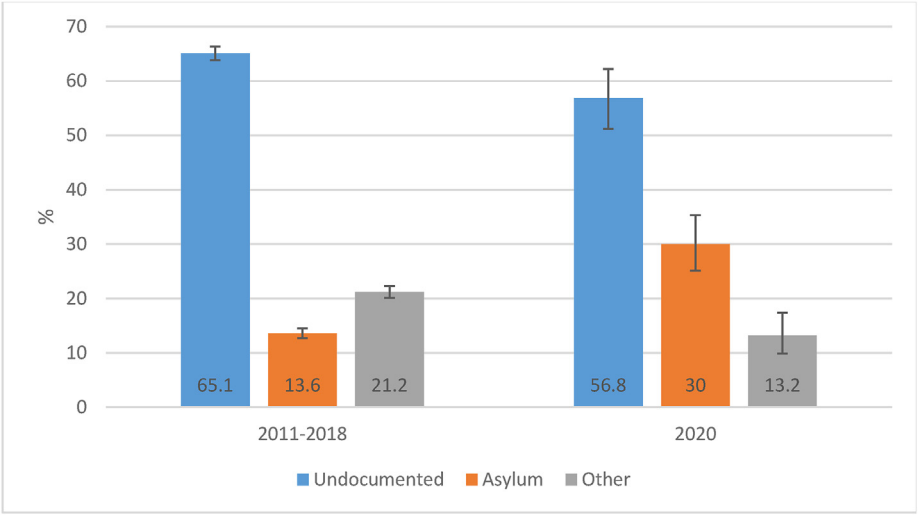

Fig. 2. Immigration status of service users visiting DOTW UK prepandemic ($N = 5371$, 576 observations missing) and pandemic ($N = 310$, 11 missing) periods.

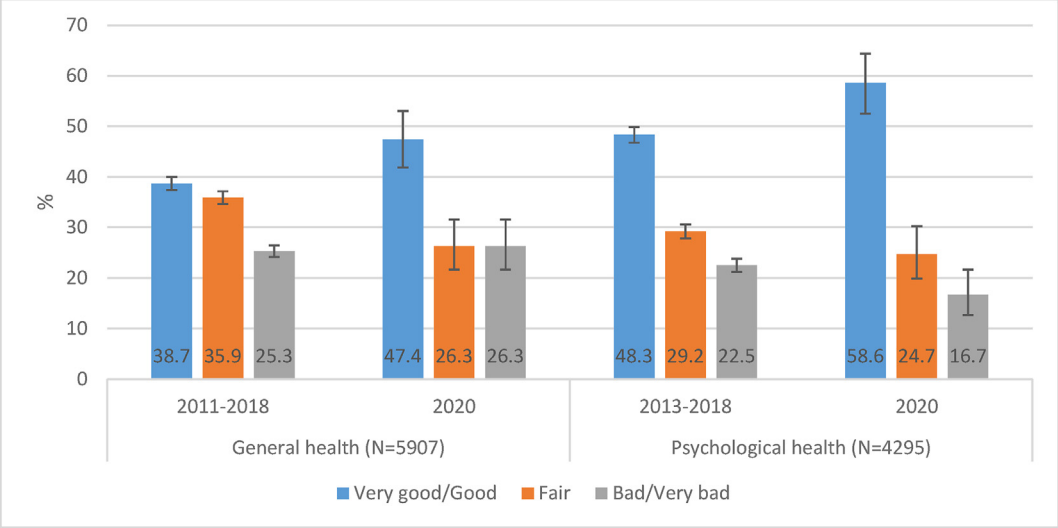

Fig. 3. Self-reported health status of service users during prepandemic and pandemic periods. For general health, $N = 5603$ (344 missing) in the prepandemic period and $N = 304$ (17 missing) during the pandemic period. For psychological health, $N = 4032$ (1915 missing, because 2011 and 2012 data do not have information about psychological health) during the prepandemic period and $N = 263$ (58 missing) during the pandemic period.

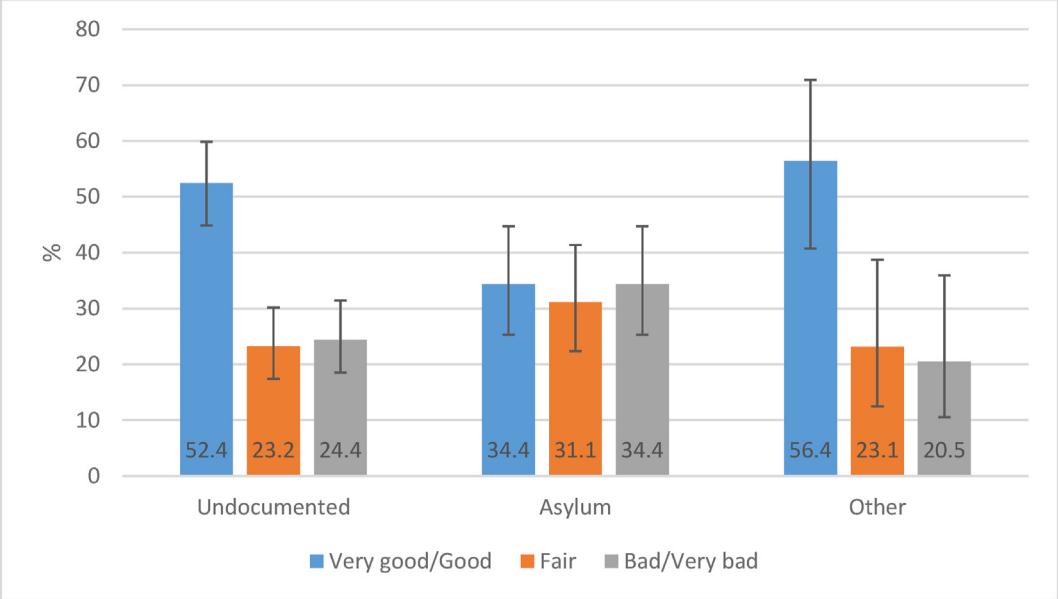

Fig. 4. Self-reported general health by the immigration status of service users who visited DOTW UK during the pandemic period ($N = 297$, 24 missing). $N = 168$, 90 and 39, for undocumented migrants, asylum seekers and others, respectively. This is a small sample because this figure only covers the pandemic period.

periods. Notes showed a few instances of service users needing help with bills incurred while receiving hospital care.

Barriers to healthcare access

As noted above, help to access healthcare was the main reason for consulting. Users faced multiple barriers including lack of understanding of the healthcare system (23.4%, 75/321). Administrative barriers (11.8%, 38/321) were important although reduced from prepandemic times. The notes recorded that some GP practices refused to register new patients during the pandemic with individuals struggling to communicate with practices registering remotely. The notes also evidenced that technological or financial barriers impeded GP registration (i.e. poor access to devices and data). A few service users worried that they might be detained by immigration services if they tried to register. Finally, financial barriers were raised linked to the ability to pay for medication or secondary care. Most barriers were resolved by DOTW UK although the notes revealed that seeking resolution could be a lengthy process, requiring multiple interventions by DOTW UK.

Discussion

In this study, we sought to understand the living conditions, changes in service user profile and needs of vulnerable migrants trying to access healthcare in the early stages of the COVID-19 pandemic. There were clear differences in the number and needs of service users accessing DOTW UK's services prepandemic and

during the pandemic. As services shifted to remote, consultations reduced markedly and the profile of service users changed to younger users and asylum seekers. An increase in the number of asylum seekers being housed in hotels in London during the pandemic[d] was one factor driving this change as they were not supported by accommodation providers to access GP registration. Additionally, it may reflect that they were given free access to Wi-fi and thus able to engage remotely with DOTW UK.[13]

There was a reduction in older users, undocumented migrants and individuals with poor health which could mean that those in the greatest need were being excluded, perhaps because of a digital divide evidenced in some groups of migrants prepandemic and mentioned in the free-notes around access to GPs.[15] The relative decrease in undocumented service users may relate to difficulties accessing the necessary devices, telephone minutes and data when destitute.[7] Certainly we find evidence that the shift to virtual consultations increased existing inequalities in healthcare access for vulnerable migrants reinforcing previous work.[9] The income and living conditions of users declined with more reporting low incomes and living in insecure housing reflecting evidence elsewhere of migrants experiencing higher likelihood of financial hardships,[3,16] unsurprising given the predominance of vulnerable migrants in service industries worst hit in lockdown.[17] Such hardship may have promoted movement from rented housing to sharing with friends and family.

Although the numbers of users reporting good health increased in the pandemic, we find that asylum seekers were more likely to report poor general and psychological health reflecting concerns expressed by the Refugee Council of the healthcare implications of living in hotels.[13] Our findings reflect the alarm expressed by NGOs, particularly after an incident in which an asylum seeker, suffering from deteriorating mental health after a lengthy hotel residence, stabbed six others and was shot dead by police.[14]

The need to register with a GP continued to be the most important reason for contacting DOTW UK with the main barrier to registration being a lack of knowledge, reflecting the importance of cultural health capital to enable meaningful healthcare access.[18] In addition, we suggest that anxiety associated with the possibility of COVID-19 infection prompted some migrants to register with healthcare providers although they were in good health.

The proportion of individuals reporting being denied access to healthcare and facing administrative barriers reduced during the pandemic. This may reflect a more open attitude to offering healthcare to undocumented migrants as public health officials promoted the importance of attending to the health of all, although organisations such as the Joint Council for the Welfare of Immigrants (JCWI) reported that migrants remained fearful of using such services.[19]

Limitations

Our data analysis covers only the early pandemic period. Over time, service users may have become more accustomed to remote provision and returned in larger numbers. The questionnaire data do not cover the whole population, because of the incomplete match between service users, social and medical forms and missing information. The variable for psychological health was defined using different questions prepandemic and during-pandemic because DOTW UK updated their questionnaire. The qualitative data only constitute the notes made by volunteers, which provided 'snapshots' but did not respond to systematised questions. Given the shift in data collection from face-to-face to phone conversations may also have affected the nature of responses.

Conclusions

Our paper offers the first quantitative analysis of vulnerable migrants' living conditions and healthcare needs in the COVID-19 pandemic. We highlight a reduction in the number of service users accessing DOTW UK's services. Users reported barriers to access associated with GP registration and healthcare costs. Service users were younger, reported better health and were more likely to be asylum seekers. The reduction in older users and those in poorer health may relate to barriers encountered engaging with DOTW UK via remote consultations. Given that many clinical services continue to operate remotely 18 months after the introduction of the first lockdown, it is important to consider the policy implications of such provision on vulnerable migrants such as older migrants and those in worse health. It is necessary to find ways to provide face-to-face services for excluded groups and to ensure that GP surgeries register patients regardless of the immigration status. Further research is needed to examine the longer-term effects of the pandemic on vulnerable migrants.

Author statements

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Ethical approval

This work has been approved by the ethical committees of the University of Birmingham and Doctors of the World and subjects gave informed consent to the work.

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Competing interests

None declared.

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[d] During the pandemic, the UK's asylum dispersal system which moves people on a no-choice basis into residential housing across the UK was suspended and evictions from dispersal accommodation ceased for failed asylum seekers and new refugees. Many recently arrived asylum seekers were housed in contingency accommodation, with over 40 hotels in use in London alone. Hotel accommodation is intended for short stays but asylum seekers spent many months with limited access to laundry, cooking and other facilities. In some cases, right-wing activists entered the hotels unchallenged to harass occupants and there were reports of high concentrations of COVID-19 cases because of overcrowding in hotels.

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